Incident Reporting in Healthcare: How to Improve Patient Safety

Incident reporting in healthcare is an important means of improving patient safety. When medical errors, injuries, and equipment failures that harm patients, caregivers, visitors, or staff are reported, you can identify safety hazards and intervene to mitigate risks and reduce harm. The more you can do to increase the number of incidents reported, the better. After all, you can only learn from the mistakes that you know about.

The biggest barrier to reporting incidents is often fear. Healthcare providers may hesitate to report an incident for fear that they will be held accountable, and their performance record will suffer. Embarrassment can also be a barrier. Providers may be so ashamed of a mistake that the last thing they want to do is relive it all in an incident report.
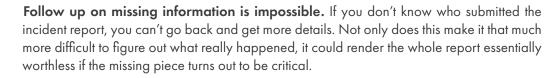
Anonymous – or "fear-free" – reporting can go a long way toward quelling these anxieties. Being able to report an incident or near miss without naming names can help put the focus back where it should be – on patient safety.

Cons of Anonymous Healthcare Incident Reporting

As a culture of safety takes root, however, the drawbacks of anonymity start to emerge.

Follow up on missing information is impossible. If you don't know who submitted the incident report, you can't go back and get more details. Not only does this make it that much more difficult to figure out what really happened, it could render the whole report essentially worthless if the missing piece turns out to be critical.

The incident is disconnected from the outcome. People like to know that their actions made a difference in patient safety. Since anonymity leaves no way to communicate back what actions were taken, reporters can feel like it was a lot of effort for nothing. Next time, they might not bother.

Learning is thwarted. Protecting the identity of the reporter can make it harder to get the team together, openly discuss what happened, and brainstorm solutions.

Move from Fear-Free to Blame-Free Incident Reporting in Healthcare

The need for the protection of anonymity often fades as people get comfortable with the process and see results. At that point, you may want to consider taking the next step – blame-free incident reporting.

With blame-free incident reporting, reporters are willing – even eager – to attach their name to the report in the interest of improving patient safety. This gives you a source to go back for clarification or augmentation, which makes the information significantly more valuable. And seeing the positive impact on patient outcomes is perhaps the best incentive for others to step up and do the same.

To reap the benefits of blame-free incident reporting, safety must be deeply ingrained in the culture. Here are five ways you can boost your safety culture – and in the process capture more incidents and near misses with more meaningful data:

1. **Communicate success stories.** Share stories where incident reporting made a real difference to a patient outcome – and be specific. Instead of simply saying that an incident report helped reverse a medication error, for instance, explain that the incident report was instrumental in stopping a child from leaving the hospital in time to reverse a dangerous medication error before any damage was done.

2. **Close the loop.** People like to know they had an impact on patient outcomes. When an incident report is received, promptly respond to the reporter with thanks. And once any investigation is complete, follow up with a second email explaining what actions were taken and the result.

3. **Conduct daily stand-up meetings.** Regular, informal meetings where the group can openly discuss what happened and brainstorm solutions can strengthen the bond among co-workers and foster a community of trust and unity.

4. **Celebrate action.** Even the most careful people sometimes make mistakes. But instead of focusing on what went wrong, commend the person for catching the mistake in time to prevent harm. Something as simple as changing the terminology from "near miss" to "good catch" can put a positive spin on what happened, which can have a dramatic impact on attitudes – and actions.

5. **Be transparent.** It's one thing for an incident report to fix an isolated incident, but quite another when that data is combined with other reports to significantly improve patient outcomes across the board. Sharing that result can be incredibly empowering to everyone who contributed.

Make It Easy to Report a Problem

Outdated technology can sabotage even the best of intentions. Paper-based forms that are hard to find – and even harder to complete – drag down the incident reporting rate, no matter how well-intentioned the staff.

How many incidents go unreported if, for instance, a nurse runs out of time before she can hunt down a paper form or figure out confusing technology? And what happens if that nurse does manage to report the incident, but sees no action taken? Patient safety suffers, to be sure – but it's also hard for a safety culture to take root when the effort to make a report doesn't seem to make a difference.

Updated technology that offers on-the-go access to easy-to-complete forms shaves precious minutes off the reporting process. Not only does this make it more likely a physician or nurse can squeeze in an incident report while juggling patient demands, but the information can be captured when details are still fresh.

Modern incident reporting software helps cultivate a safety culture by making it quick and easy to report incidents – then turn that information into actions that make a visible difference in patient outcomes. Here's how:

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Express incident entry. Incident reporting software uses intuitive, survey-style questionnaires with auto-filled fields, barcode scanning capabilities, and picture-based lookup features to shave precious minutes off the reporting process – which makes it much more likely a physician or nurse can squeeze it in between patients.

On-the-go access. Incidents and near misses can be reported from anywhere on any device with an internet connection – which means the information is captured when the details are still fresh.

No expertise required. Healthcare workers are experts in caring for patients, not risk management. Online entry forms show only relevant questions and guide users through the reporting process to capture complete and accurate information from any user.

Speak up. Healthcare professionals reporting events using today's software can choose to identify themselves – or not. While knowing who made the report is preferable (in case there are follow-up questions), the end goal is for all incidents and near misses to be reported, so it's important that everyone feel comfortable speaking up. And if multiple people report the same event, the software will automatically combine those reports into one complete file so every voice can be heard.

The whole story – all in one place. As soon as an event is reported, software can automatically notify everyone who needs to know what happened. You can see data in real-time, along with relevant pictures, documents, and other information that will help you take swift action.

Connect the dots. Software also can show real-time incident metrics by month, type of injury, body part, and more – and it can benchmark past performance against current results to determine if your actions were effective. In short, you have everything you need right at your fingertips to identify early-warning signs and trends so you can quickly intervene.

Seeing is believing. There's nothing like being able to see that your incident report helped even one patient. But when that data is combined with other reports to significantly improve patient outcomes across the board, the impact can be monumental – on staff as well as patients.

Nurses, doctors, and other healthcare workers are the eyes and ears of your patient safety program – and it's critical to capture their frontline knowledge of issues and problems in incident reports. The key to breaking down barriers with incident reporting in healthcare is to build a blame-free culture, supported by easy-to-use technology. With open lines of communication, mistakes can be shared, learned from, and fixed. That's an environment where a safety culture will grow and thrive.

For more on improving patient safety through risk management, visit riskonnect.com.